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Wednesday, January 6, 2010; A04

As House and Senate lawmakers start to reconcile their health-care bills with an eye to final passage, a little-noticed provision is already prompting celebration from a small group of influential hospitals that stand to gain millions in Medicare dollars

Language in both the House and Senate bills would reward hospitals for efficiency in their Medicare spending, a dramatic change in the formula for parceling out the public dollars, which can account for as much as half of a hospital's budget. That could prove to be a windfall for some hospitals but a significant loss of funding for others, mostly those in big cities and the South.

A revised Medicare formula represents a major lobbying victory for a coalition of hospitals based in the upper Midwest, led by the Mayo Clinic. Their leaders sent a letter to House members in July demanding Medicare reform, as well as objecting to a government-run insurance plan, or "public option." Even the smallest in the group mobilized lobbyists and sent their leaders to Capitol Hill to press their case.

Mayo leaders met with White House officials several times in recent months, convincing them that "paying for value" was key to slowing the growth in health-care costs. Throughout, President Obama has praised Mayo and "high-value" care.

"We are extremely pleased," said Karl Ulrich, president of the Marshfield Clinic in Wisconsin, a member of the coalition. He predicted a period of transition "that will be difficult for other providers to adapt to" but added: "We just think it's the way to go."

But those on the losing end are criticizing the provision as a brazen money grab. They predict

that, instead of saving taxpayer money, it will simply take funding from areas with more poverty and racial minorities and send it to more homogenous communities that tend to have fewer health problems.

"The people in Minnesota are just going to say, 'We want our money,' " said J. Thomas Rosenthal, chief medical officer of the UCLA Medical System. "It's just 'Give us your money. You people are wasteful and we're not, and we deserve it.' "

Regional differences

Medicare payment rates are based on a mix of factors, including regional differences in the cost of living. Doctors and hospitals across the country have argued that the system underpays them for their services, but those in the Midwest, Mountain West and Northwest have been particularly aggrieved.

Hospitals in those regions perform well in oft-cited rankings by Dartmouth College researchers, which measure per-patient Medicare spending. And many of those hospitals also rank high in the quality of their care, suggesting it is possible to restrain the volume of medical procedures without affecting care.

Meanwhile, Dartmouth's surveys find that hospitals in some areas -- led by Miami, Los Angeles, New York City, and much of Texas and the South -- spend far more per Medicare patient than hospitals elsewhere.

That type of measurement is at the heart of the language in the health-care bills, which would introduce a "value index" or "payment modifier" to reward more efficient providers.

Just how much money is at stake depends on how the index is crafted. But even before the details are ironed out, many health policy experts say the provision may be one of the strongest cost-control tools in the legislation.

Hospitals now have little incentive to be parsimonious, because Medicare revenue is based on the number of procedures performed at a facility. But supporters say a value index -- by rewarding hospitals that spend less per patient -- would provide an incentive to limit procedures.

Proponents acknowledge one problem: Medicare rates will probably be set at a city-wide or regional level, rather than hospital by hospital. That means providers, even if they are efficient, could be punished for being in high-spending areas -- and inefficient hospitals could be rewarded if they are in low-spending areas. But supporters hope the change would encourage providers to better coordinate care, to improve their area's score.

"It's a step forward," said Donald Berwick, head of the Institute for Healthcare Improvement, a Massachusetts think tank.

Complicating factors

But opponents say Congress has bought a flawed sales pitch. They point out that the Midwestern hospitals spend less in part because they serve fewer low-income patients and racial minorities, who have higher rates of diabetes, high blood pressure and other costly conditions.

Opponents cite a new report from MedPAC, the Medicare advisory commission, which found that the spending gap between the Midwestern towns and urban cities such as Boston and New York shrinks when other factors are taken into account, including patients' health status and the fact that teaching hospitals get higher payments and thus appear to be spending more per patient.

Other data suggest that the rankings look much different when all hospital spending -- not just Medicare -- is taken into consideration. In some cases, for example, hospitals that spend little on Medicare charge very high rates to private insurers. "Just because you end up with lower Medicare spending doesn't mean you're efficient," said Len Nichols of the New America Foundation.

While lawmakers from losing states complained about the provision, they were less effective than a well-organized group of Democrats from states likely to gain, including Sen. Maria Cantwell (Wash.) and Reps. Betty McCollum (Minn.), Ron Kind (Wis.) and Bruce Braley (Iowa.).

Now, the focus in Congress is on the precise language that will be included when the House and Senate bills are merged. Both sides agree that the House bill is most favorable to the "high-value" hospitals, because it kicks into gear faster and assigns the task of crafting the value index to the Institute of Medicine, a newcomer to the process, instead of the Department of Health and Human Services, which may be less inclined to radically depart from the system it has administered for years.

Lawmakers in the House who support the use of a value index recently wrote to Speaker Nancy Pelosi (D-Calif.) demanding that their language prevail But whatever the final language, they feel as if they have won.

"The quality-care coalition made clear we weren't going to vote for a bill that continued these disparities," McCollum said. House leaders, she said, "knew they needed our votes to pass this."